

3142

CERTIFICATE OF DEATH

Reg. Dist. No.

03130

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution:—Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Barnes Street		d. STREET ADDRESS Barnes Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle F. Last Bauer		4. DATE OF DEATH Month March Day 24 , Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1898
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (State or foreign country) Bel Air, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Bauer		14. MOTHER'S MAIDEN NAME Annie Ferry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.#1		16. SOCIAL SECURITY NO. 215-07-0805	
17. INFORMANT (Wife) Mrs. Mary D. Bauer		Address Barnes St. Bel Air, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident - hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) general arteriosclerosis - DUE TO (c) essential hypertension		INTERVAL BETWEEN ONSET AND DEATH instantaneous adult years 10 + years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) old severe myocardial infarction - 10 yrs. ago		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1961 , to 24 Mar., 1961 , that I last saw the deceased alive on 11 March, 1961 , and that death occurred at 4:40 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Warren R. Lesch, MD		ADDRESS (Street, city or town, state) 202 S. MAIN - Bel Air, MD	
PHYSICIAN'S NAME (Type) Warren R. Lesch, M.D.		DATE SIGNED 3/24/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 27, 1961	
22c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Harf. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster		24a. REC'D BY REGISTRAR W. Broadway & Williams Bel Air, Maryland	
24b. REGISTRAR'S SIGNATURE Arthur S. Traub		DATE MAR 27 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. This certificate may be obtained by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: Enter this certificate for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

21. BROWNE, J. H. 1961. The Maryland State Department of Health - Baltimore, 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3143

CERTIFICATE OF DEATH

Reg. Dist. No. 03131

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewood</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewood</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>21 Walters Road</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Bernice</i> Middle <i>Elizabeth</i> Last <i>Bennett</i>				4. DATE OF DEATH Month <i>March</i> Day <i>17th</i> Year <i>1961</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6/1/1913</i>	
9. AGE (In years last birthday) yrs. <i>47</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>I B M. operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HRG. Mfg. (Ent.)</i>		11. BIRTHPLACE (State or foreign country) <i>Kansas</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>				13. FATHER'S NAME <i>(Unknown)</i>			
14. MOTHER'S MAIDEN NAME <i>(Unknown)</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>(Unknown)</i>				17. INFORMANT <i>Edwin E. Bennett, Edgewood, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of rectum, with</i> <i>154X</i> DUE TO <i>generalized metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 years</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>June 5, 1960</i> , to <i>March 15, 1961</i> , that I last saw the deceased alive on <i>March 15, 1961</i> , and that death occurred at <i>11:45 P</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Romulo V. Goco</i> M.D.				ADDRESS (Street, city or town, state) <i>1800 Freedom Way N</i>			
PHYSICIAN'S NAME (Type) <i>Romulo V. Goco, M.D.</i>				DATE SIGNED <i>Baltimore 13 Md 3/18/61</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>3/20/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Andrews Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Wilmington, N.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Barring - Aberdeen, Maryland</i>				24a. REC'D BY REGISTRAR DATE <i>MAR 22 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Charles E. Finner</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 03132

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE	
c. LENGTH OF STAY IN 1b LIFE		d. STREET ADDRESS 317 N. STOKES, ST.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 317 N. STOKES, ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH LOUISE BENNETT		4. DATE OF DEATH Month Day Year MAR 14 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 5, 1903
9. AGE (In years lost birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CANNING HOUSE	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer E. BENNETT		14. MOTHER'S MAIDEN NAME MARYE. GRAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT ZELMA B. KELLY, HAVRE DE GRACE MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 14 19 61 , to Mar. 14 19 61 , that (I) (we) last saw the deceased alive on Mar. 14 19 61 , and that death occurred at 11:00 M, from the causes and on the date stated above.			
22a. SIGNATURE Wm. H. Wadsworth M.D.		22b. DATE SIGNED 3/17/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS HAVRE DE GRACE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-17-1961	
23c. NAME OF CEMETERY OR CREMATORY CHARLESTOWN CEM.		23d. LOCATION (City, town, or county) (State) CECIL CO. MD	
24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell		25a. REC'D BY REGISTRAR DATE MAR 20 '61	
ADDRESS HAVRE DE GRACE MD		25b. REGISTRAR'S SIGNATURE William S. Kraus	

CERTIFICATE OF DEATH

1146

CHILD LIVING

PROSECUTION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3145

CERTIFICATE OF DEATH

Reg. Dist. No.

03133

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural—Bel Air</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Almshouse—Harford Co.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SYLVESTER STREETT BILLINGSLEY</u>		4. DATE OF DEATH Month Day Year <u>March 15, 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 22, 1882</u>
9. AGE (In years last birthday) <u>79 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter—retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Perry Hall, Balt. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David S. Billingsley</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Streett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>20-475-755</u>	
17. INFORMANT <u>Mrs. Alma Moore, Fullerton, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive Heart failure (pulmonary Edema)</u> DUE TO (b) <u>Chr. Cardio-vascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chr. Bronchial asthma</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1, 1959</u> , to <u>March 15, 1961</u> , that I last saw the deceased alive on <u>March 13, 1961</u> , and that death occurred at <u>5:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Willard P. Hudson, M.D.</u> <u>Mar. 15, 1961</u>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u> <u>Forest Hill, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/18/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillside</u>		22d. LOCATION (City, town, or county) (State) <u>Roslyn Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Rutz</u>		ADDRESS <u>Jarrettsville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

3125

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF WITNESS		NAME OF MINISTER		NAME OF CLERGYMAN	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH	
DISEASE		SYMPTOMS		TREATMENT		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERGYMAN		SIGNATURE OF WITNESS		SIGNATURE OF MINISTER		SIGNATURE OF CLERGYMAN		SIGNATURE OF CLERGYMAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
NAME OF PHYSICIAN		NAME OF CLERGYMAN		NAME OF WITNESS		NAME OF MINISTER		NAME OF CLERGYMAN		NAME OF CLERGYMAN	
ADDRESS OF PHYSICIAN		ADDRESS OF CLERGYMAN		ADDRESS OF WITNESS		ADDRESS OF MINISTER		ADDRESS OF CLERGYMAN		ADDRESS OF CLERGYMAN	
CITY OF PHYSICIAN		CITY OF CLERGYMAN		CITY OF WITNESS		CITY OF MINISTER		CITY OF CLERGYMAN		CITY OF CLERGYMAN	
STATE OF PHYSICIAN		STATE OF CLERGYMAN		STATE OF WITNESS		STATE OF MINISTER		STATE OF CLERGYMAN		STATE OF CLERGYMAN	
COUNTY OF PHYSICIAN		COUNTY OF CLERGYMAN		COUNTY OF WITNESS		COUNTY OF MINISTER		COUNTY OF CLERGYMAN		COUNTY OF CLERGYMAN	
ZIP CODE OF PHYSICIAN		ZIP CODE OF CLERGYMAN		ZIP CODE OF WITNESS		ZIP CODE OF MINISTER		ZIP CODE OF CLERGYMAN		ZIP CODE OF CLERGYMAN	

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
3146 MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
03134													
1. PLACE OF DEATH a. COUNTY <i>Harford</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hamden Place</i>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>320 Rogers St.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Harford Memorial Hospital</i>				d. STREET ADDRESS <i>Aberdeen, Md.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Nicholas J. Bonge</i>				4. DATE OF DEATH <i>March 27 1961</i>									
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>August 17, 1910</i>		9. AGE (In years last birthday) <i>50</i>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Civil Engineer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Engineering</i>				11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Louis Bonge</i>				14. MOTHER'S MAIDEN NAME <i>Valarie Scorano</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO.				17. INFORMANT <i>Marie I. Bonge</i> Address <i>320 S. Rogers St. Aberdeen, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture Skull</i> 901.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell off ladder</i>									
20c. TIME OF INJURY Month, Day, Year Hour <i>4</i> p.m. <i>3-26 1961</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Aberdeen</i> (County) <i>Harford</i> (State) <i>Md</i>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Gerald E Palmer</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Beltin, Md.</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <i>Gerald E Palmer MD</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <i>3-27-61</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>3/30/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Harford Memorial Gardens</i>		22d. LOCATION (City, town, or country) (State) <i>R.D. Aberdeen, Md.</i>					
23. FUNERAL DIRECTOR <i>John E. Tarring</i>				ADDRESS <i>Tarring Funeral Home Aberdeen, Md.</i>				24a. REC'D BY REGISTRAR <i>APR 3 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3147

CERTIFICATE OF DEATH

Reg. Dist. No. 03135

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace,		c. LENGTH OF STAY IN 1b 7.0 H.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HELEN Last BOSTIC		4. DATE OF DEATH Month March Day 27 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1899
9. AGE (In years last birthday) yrs. 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Edward Crist		14. MOTHER'S MAIDEN NAME Lillian Kyser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-14-2619	
17. INFORMANT Olen Bostic, R.D. 2, Aberdeen, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X DUE TO Mesenteric Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mitral Stenosis & Decompensat. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs 8 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 19 1961 to March 19 1961 , that I last saw the deceased alive on March 15 1961 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Ralph Horky		DATE SIGNED Churchville, Md.	
PHYSICIAN'S NAME (Type) J. Ralph Horky, M.D.		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/30/61	22c. NAME OF CEMETERY OR CREMATORY St. Paul Meth. Cemetery, Norrisville, Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE John G. Barrung		24a. REC'D BY REGISTRAR DATE APR 3 1961	
ADDRESS Aberdeen, Md.		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1947

1. NAME OF DECEASED <i>John W. Smith</i>		2. SEX <i>Male</i>	
3. AGE <i>65</i>		4. DATE OF BIRTH <i>Jan 15 1882</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Retired</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>1910</i>	
9. NAME OF SPOUSE <i>John W. Smith</i>		10. DATE OF DEATH <i>Dec 10 1947</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>		12. PLACE OF DEATH <i>Home</i>	
13. SIGNATURE OF PHYSICIAN <i>John W. Smith</i>		14. SIGNATURE OF REGISTRAR <i>John W. Smith</i>	
15. SIGNATURE OF WITNESSES <i>John W. Smith</i>		16. SIGNATURE OF DECEASED <i>John W. Smith</i>	
17. SIGNATURE OF FUNERAL HOME <i>John W. Smith</i>		18. SIGNATURE OF BURIAL PLACE <i>John W. Smith</i>	
19. SIGNATURE OF INTERVIEWER <i>John W. Smith</i>		20. SIGNATURE OF REVIEWER <i>John W. Smith</i>	
21. SIGNATURE OF APPROVER <i>John W. Smith</i>		22. SIGNATURE OF SUPERVISOR <i>John W. Smith</i>	
23. SIGNATURE OF CHIEF OF BUREAU <i>John W. Smith</i>		24. SIGNATURE OF DIRECTOR <i>John W. Smith</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G283 3/22/61 mh

3148

CERTIFICATE OF DEATH

Reg. Dist. No.

03138

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. LENGTH OF STAY IN lb <u>25 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jerusalem Rd</u>		d. STREET ADDRESS <u>1 Jerusalem Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>Dudley</u> Middle <u>Bridges</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 28 1906</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR: Months <u>5</u> Days <u>13</u> Hours <u>19</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Jerusalem Mills</u>	
11. BIRTH PLACE (State or foreign country) <u>So. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Canada Bridges</u>		14. MOTHER'S MAIDEN NAME <u>Hanna E. Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-10-6696</u>	
17. INFORMANT Address <u>Mrs. Elizabeth Ningard - Jerusalem Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer Stomach</u> DUE TO <u>15 IX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>15 IX</u> DUE TO (c) <u>15 IX</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec.</u> , 19 <u>60</u> , to <u>March</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 10</u> , 19 <u>61</u> , and that death occurred at <u>2:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		DATE SIGNED <u>Kingsville, Md. 3-13-61</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-9-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Christian Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Joppa (Harford Co.) Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Larsen Fun'l Home</u>		ADDRESS <u>7401 Belvid Rd.</u>	
24a. REC'D BY REGISTRAR <u>MAR 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

James E. Miller
3-4-61
Marion (Mrs.)
Marion (Mrs.)

Marion (Mrs.)
Marion (Mrs.)

25-10-1961 - 25-10-1961

James E. Miller

Marion (Mrs.)

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Marion (Mrs.)

25-10-1961

Marion (Mrs.)

Marion (Mrs.)

25-10-1961

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3149

CERTIFICATE OF DEATH

03137

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL HAVER DE GRACE</u> c. LENGTH OF STAY IN 1b <u>—</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CE. MARYLAND AVE. + LYONS ST.</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL HAVER DE GRACE</u> d. STREET ADDRESS <u>MARYLAND AVE + LYONS, ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>AMY HALL BROWN</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>29</u> Year <u>1961</u>		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>FEBRUARY 12, 1885</u> 9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (Country & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>CHARLES TAYLOR WILSON</u>		14. MOTHER'S MAIDEN NAME <u>SERENA BATEMAN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>ALICE B. REASIN HAVER DE GRACE HEIGHTS MD.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> 331X DUE TO (b) <u>Generalized Cerebrovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>14 MIN.</u> <u>64 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> e.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 3, 1955</u> to <u>June 29, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 26, 1961</u> , and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Dudley Phillips MD</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		22d. ADDRESS <u>DARLINGTON, MARYLAND</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APR 1, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cem</u>			
23d. LOCATION (City, town or county) <u>HAVER DE GRACE MD</u>		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell, Haver de Grace MD.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			
DATE <u>APR 4 '61</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(14)

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Handwritten notes, possibly a list or index, with some entries marked with 'X'.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03138

3150

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. LENGTH OF STAY IN 1b <u>4 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford County Home, Bel Air, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Earl</u> Last <u>Bryant</u>				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 9, 1900</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed.</u>			
13. FATHER'S NAME <u>William Bryant</u>				14. MOTHER'S MARRIED NAME <u>Willie Weaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Edna Martee = Box 453 - Perryville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u>Chronic cardio-vascular disease.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 6, 1956</u> , to <u>March 19, 1961</u> , that I last saw the deceased alive on <u>March 17, 1961</u> , and that death occurred at <u>10:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard P. Hudson</u>				ADDRESS (Street, city or town, state) <u>Forest Hill, Maryland</u>			
DATE SIGNED <u>March 20, 1961</u>							
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westway Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen, Rural - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barrung - Aberdeen, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be obtained by the attending physician or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11-10

DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR RELIGION EDUCATION SERVICE GRADE BRANCH COMPANY REGIMENT DIVISION CORPS SERVICE NUMBER GRADE BRANCH COMPANY REGIMENT DIVISION CORPS SERVICE NUMBER		PLACE OF DEATH STREET CITY COUNTY STATE ZIP CODE DATE OF DEATH TIME OF DEATH PLACE OF DEATH STREET CITY COUNTY STATE ZIP CODE DATE OF DEATH TIME OF DEATH	
CAUSE OF DEATH 1. IMMEDIATE 2. INTERMEDIATE 3. REMOTE 4. UNDERLYING 5. OTHER		MANNER OF DEATH 1. ACCIDENT 2. SUICIDE 3. HOMICIDE 4. NATURAL 5. UNKNOWN	
SIGNATURE OF DECEASED SIGNATURE OF WITNESS SIGNATURE OF PHYSICIAN SIGNATURE OF CLERK SIGNATURE OF JUDGE SIGNATURE OF SHERIFF SIGNATURE OF DISTRICT ATTORNEY SIGNATURE OF COUNTY CLERK SIGNATURE OF STATE CLERK SIGNATURE OF SECRETARY OF HEALTH SIGNATURE OF COMMISSIONER OF HEALTH SIGNATURE OF DEPUTY COMMISSIONER OF HEALTH SIGNATURE OF ASSISTANT COMMISSIONER OF HEALTH SIGNATURE OF CHIEF OF BUREAU OF VITAL STATISTICS SIGNATURE OF CHIEF OF BUREAU OF PUBLIC HEALTH SIGNATURE OF CHIEF OF BUREAU OF LABOR SIGNATURE OF CHIEF OF BUREAU OF EDUCATION SIGNATURE OF CHIEF OF BUREAU OF AGRICULTURE SIGNATURE OF CHIEF OF BUREAU OF COMMERCE SIGNATURE OF CHIEF OF BUREAU OF TRANSPORTATION SIGNATURE OF CHIEF OF BUREAU OF MINES SIGNATURE OF CHIEF OF BUREAU OF FOREST SERVICE SIGNATURE OF CHIEF OF BUREAU OF PARKS SIGNATURE OF CHIEF OF BUREAU OF RECREATION SIGNATURE OF CHIEF OF BUREAU OF CONSERVATION SIGNATURE OF CHIEF OF BUREAU OF NATURAL RESOURCES SIGNATURE OF CHIEF OF BUREAU OF HISTORIC PRESERVATION SIGNATURE OF CHIEF OF BUREAU OF ARCHITECTURE SIGNATURE OF CHIEF OF BUREAU OF ENGINEERING SIGNATURE OF CHIEF OF BUREAU OF SURVEYING SIGNATURE OF CHIEF OF BUREAU OF MAPPING SIGNATURE OF CHIEF OF BUREAU OF PHOTOGRAPHY SIGNATURE OF CHIEF OF BUREAU OF FILM SIGNATURE OF CHIEF OF BUREAU OF TELEVISION SIGNATURE OF CHIEF OF BUREAU OF RADIO SIGNATURE OF CHIEF OF BUREAU OF PUBLICATIONS SIGNATURE OF CHIEF OF BUREAU OF INFORMATION SIGNATURE OF CHIEF OF BUREAU OF COMMUNICATIONS SIGNATURE OF CHIEF OF BUREAU OF TRANSPORTATION SIGNATURE OF CHIEF OF BUREAU OF MINES SIGNATURE OF CHIEF OF BUREAU OF FOREST SERVICE SIGNATURE OF CHIEF OF BUREAU OF PARKS SIGNATURE OF CHIEF OF BUREAU OF RECREATION SIGNATURE OF CHIEF OF BUREAU OF CONSERVATION SIGNATURE OF CHIEF OF BUREAU OF NATURAL RESOURCES SIGNATURE OF CHIEF OF BUREAU OF HISTORIC PRESERVATION SIGNATURE OF CHIEF OF BUREAU OF ARCHITECTURE SIGNATURE OF CHIEF OF BUREAU OF ENGINEERING SIGNATURE OF CHIEF OF BUREAU OF SURVEYING SIGNATURE OF CHIEF OF BUREAU OF MAPPING SIGNATURE OF CHIEF OF BUREAU OF PHOTOGRAPHY SIGNATURE OF CHIEF OF BUREAU OF FILM SIGNATURE OF CHIEF OF BUREAU OF TELEVISION SIGNATURE OF CHIEF OF BUREAU OF RADIO SIGNATURE OF CHIEF OF BUREAU OF PUBLICATIONS SIGNATURE OF CHIEF OF BUREAU OF INFORMATION SIGNATURE OF CHIEF OF BUREAU OF COMMUNICATIONS		CERTIFICATE OF DEATH 1. IMMEDIATE 2. INTERMEDIATE 3. REMOTE 4. UNDERLYING 5. OTHER MANNER OF DEATH 1. ACCIDENT 2. SUICIDE 3. HOMICIDE 4. NATURAL 5. UNKNOWN	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3151

CERTIFICATE OF DEATH

Item 2b Film C282 3/16/61 mh

03139

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u> d. STREET ADDRESS <u>RD 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Burton</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>6</u> Year <u>1961</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-7-1894</u>		9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (County & State, or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Lockard</u>				14. MOTHER'S MAIDEN NAME <u>Laura Alexander</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>192-12-7173</u>				17. INFORMANT Address <u>John W Burton Rising Sun Rd 1 Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line in (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO (b) <u>Post Anesthesia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Opunt for Cancer of breast</u>																INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)									
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on..... <u>March 6, 1961</u> and that death occurred at <u>3:15 PM</u> from the causes and on the date stated above.																					
22a. SIGNATURE <u>M. K. Stender</u> M.D.										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS <u>Harre de Grace, Md</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3-10-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hopewell</u>				23d. LOCATION (City, town or county) <u>Port Deposit, Cecil Md</u> (State)											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>										ADDRESS <u>North East Md</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO FUNERAL OR BENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0310

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192-12-13 for the United States
Department of Justice
Washington, D.C.
Office of the Attorney General
Special Agent in Charge

Wm. K. Lawrence

Wm. K. Lawrence

3-15-1917
Wm. K. Lawrence
Special Agent in Charge
United States Department of Justice
Washington, D.C.

TO HOWARD HALL OF THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, if any, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3152 CERTIFICATE OF DEATH 03140											
1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen c. LENGTH OF STAY IN 1b 43mins d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) US Army Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewood d. STREET ADDRESS 154 Hawthorne Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) DONALD E CURTIS JR						4. DATE OF DEATH March 21 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 21, 1961		9. AGE (In years last birthday) 43		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DONALD E CURTIS						14. MOTHER'S MAIDEN NAME BARBARA RODUS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N/A				16. SOCIAL SECURITY NO. N/A		17. INFORMANT Donald E Curtis (Father) same as #2				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Anomaly of Gastrointestinal tract, presumed DUE TO (b) 43 Mins Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 759.3 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Prematurity										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (do not know) attended the deceased from March 21, 1961 to March 21, 1961 that (I) (do not) saw the deceased alive on March 21, 1961 , and that death occurred at 7:45 PM , from the causes and on the date stated above.											
22a. SIGNATURE Malcolm McLean M.D.						22b. DATE SIGNED March 21, 1961					
22c. PHYSICIAN'S NAME (Type) MALCOLM MCLEAN Captain, M C						22d. ADDRESS U. S. Army Hospital Aberdeen Proving Ground, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 27 Mar 61		23c. NAME OF CEMETERY OR CREMATORY Army Cemetery Center		23d. LOCATION (City, town or county) (State) Edgewood Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE John E. Tarrance ADDRESS Aberdeen Md						25a. REC'D BY REGISTRAR APR 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RYLAND
U3141

1. PLACE OF DEATH a. COUNTY <u>Hanford</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN IB <u>24</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>625 Ridgewood Road</u>		d. STREET ADDRESS <u>Mt Vista Road</u>	
3. NAME OF DECEASED (Type or print) <u>Christian Carl Dietz</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Insulating Eng.</u>	11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>
13. FATHER'S NAME <u>Christian Dietz</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-16-2745</u>	14. MOTHER'S MAIDEN NAME <u>Johanna Hauf</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)		17. INFORMANT Address <u>Kingsville Md</u> <u>Mrs Christian Dietz 535 Mt. Vista Rd.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>3-2-61</u>			
ACTUAL SIGNATURE <u>Quall E Palmer</u>		M.D.	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-3-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Luthern Cem.</u>	22d. LOCATION (City, town, or country) (State) <u>Perry Hall Md.</u>
23. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>		ADDRESS <u>740 Bel Air Road</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Harford</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hanover Branch</u>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u>		b. COUNTY <u>Cecil</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Colonia, Cecil County</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>						d. STREET ADDRESS <u>07X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Kenneth R. Dinsmore</u>		4. DATE OF DEATH <u>March 12 1961</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 17, 1905</u>	
9. AGE (In years last birthday) <u>56 yrs.</u>		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>6</u>		11. IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Colonia, md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Dinsmore</u>						14. MOTHER'S MAIDEN NAME <u>Mary J. Krauss</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>Frances Dinsmore, Colonia, md</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture intestine</u> 816 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>816 X</u> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>					
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>3/7- 1961</u> p.m.						20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt 1</u>						20f. (City or town) <u>Spready Oak</u> (County) <u>Cecil</u> (State) <u>Md.</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, md</u>					
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-12-61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>3/15/1961</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cemetery</u>						22d. LOCATION (City, town, or country) <u>Rising Sun Md.</u>					
23. FUNERAL DIRECTOR <u>Ralph M Reed, Rising Sun, md</u>						24a. REC'D BY REGISTRAR <u>MAR 14 '61</u>					
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krauss</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03143

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE c. LENGTH OF STAY IN 1b 10 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HARFORD MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY HARFORD c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE d. STREET ADDRESS 123 DEAYER ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARGARET F DRY		4. DATE OF DEATH MARCH 13 1961		5. SEX F 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 5/18/1915 9. AGE (In years last birthday) 46 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife 10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM FADELEY 14. MOTHER'S MAIDEN NAME MARGARET JONES			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Mildred Dry Address 123 Deaver St. Havre de Grace Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X Uremia - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ureteral obstruction (c) acute pyelonephritis, Chronic Glomerulonephritis, Secondary PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)					
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 20g. (County) 20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from March 3, 1961 , to March 13, 1961 , that (I) (we) last saw the deceased alive on March 13, 1961 , and that death occurred at 4:10 AM from the causes and on the date stated above.							
22a. SIGNATURE Houge Silva 22b. DATE SIGNED		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS			
23a. BURIAL - CREMATION, REMOVAL (Specify) 3/16/61 23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Angel Hill 23d. LOCATION (City, town or county) Havre de Grace Md (State)		24. FUNERAL DIRECTOR'S SIGNATURE Pennington J. Pennington ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE MAR 16 '61			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Mr. J. J. [illegible]

[Large handwritten signature]

CERTIFICATE OF DEATH

2156

W. C. BOND

Name of Deceased		Date of Death	
Sex		Age	
Race		Place of Birth	
Usual Residence		Cause of Death	
Occupation		Manner of Death	
Signature of Physician		Signature of Registrar	
Date		Place	

Colburn & Knapp

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3158

CERTIFICATE OF DEATH

03146

1. PLACE OF DEATH a. COUNTY HARFORD b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HARFORD MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABINGDON d. STREET ADDRESS Box 67 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Boy		First 'A' Middle 'A' Last HARRIS		4. DATE OF DEATH MAR. 25 1961			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 21 1961	9. AGE (In years last birthday) 4 yrs.	IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) HARFORD Co. MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Kenneth Eugene Norton		14. MOTHER'S MAIDEN NAME MILDRED R. HARRIS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity & Atelectasis 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) no							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 3/21 to 3/25 , 1961, that (I) (we) last saw the deceased alive on 3/25 1961, and that death occurred at 4 AM, from the causes and on the date stated above.							
22a. SIGNATURE George T. Stansbury		M.D.		22b. DATE SIGNED 3/25/61			
22c. PHYSICIAN'S NAME (Type) George T. Stansbury		22d. ADDRESS 569 Revolution St. Havre de Grace, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-25-61	23c. NAME OF CEMETERY OR CREMATORY Abingdon Methodist Cem.	23d. LOCATION (City, town or county) (State) Abingdon, Harford Co. Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullenk		ADDRESS Havre de Grace, Md.		25a. REC'D BY REGISTRAR DATE MAR 30 '61	25b. REGISTRAR'S SIGNATURE Carlton L. Howard		

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 9/60

08140

0108

(M)

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "MAR 21 1961" and "U.S." are visible.]

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3159											
03147											
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>				c. LENGTH OF STAY IN 1b <u>20 hrs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABINGDON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>Box 67</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
6. NAME OF DECEASED (Type or print) <u>Baby Boy "B" HARRIS</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>22</u> Year <u>1961</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/21/61</u>		9. AGE (In years last birthday) <u>30</u>		IF UNDER 1 YEAR Months <u>30</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MD (Harford Co.)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kenneth Eugene Norton</u>				14. MOTHER'S MAIDEN NAME <u>Mildred HARRIS</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Hospital Records</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity & Congenital Atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 21, 1961</u> to <u>March 22, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 22, 1961</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>George T. Stansbury</u>				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/24/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				22d. ADDRESS <u>569 Revolution St. Haverde Grace, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-24-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Abingdon Methodist Cem</u>		23d. LOCATION (City, town or county) (State) <u>Abingdon, Harford Co. Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bullcock</u>				ADDRESS <u>Haverde Grace, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 30 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
3160 CERTIFICATE OF DEATH														
03148														
1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Army Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Baltimore g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore h. STREET ADDRESS 3403 Crosshill Court i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Infant Girl HEMPTON					4. DATE OF DEATH Month March Day 21 Year 19 61									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19, 1961		9. AGE (In years last birthday) yrs. 2 IF UNDER 1 YEAR: Months 2 Days 2 Hours 2 Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME RICHARD PETER HEMPTON					14. MOTHER'S MAIDEN NAME EDNA LOUISE WAGNER									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N/A					16. SOCIAL SECURITY NO. N/A					17. INFORMANT Mrs Edna L Hempton (Mother) Address Baltimore, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity, severe (Approx 6½ months gestation) DUE TO (b) 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 776X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) Malcolm McLean attended the deceased from March 20, 1961 , to March 21, 1961 , that (I) not saw the deceased alive on 20 March 1961 , and that death occurred at 730A , from the causes and on the date stated above.														
22a. SIGNATURE Malcolm McLean M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U. S. Army Hospital			22b. DATE SIGNED March 21, 1961						
22c. PHYSICIAN'S NAME (Type) MALCOLM MCLEAN Captain, MC					22e. ADDRESS Aberdeen Proving Ground, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)								
Burial		3/22/1961		Post cemetery		Aberdeen Proving G. Md.								
24. FUNERAL DIRECTOR'S SIGNATURE Loring Truitt					25a. REC'D BY REGISTRAR DATE MAR 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline							

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1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3161

03149

| | | | | | | | |
|--|--|---|---|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>HARFORD</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural ABERDEEN</u> | | | | c. LENGTH OF STAY IN 1b
<u>20 YRS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>ABERDEEN MD. R.D. 3</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>CHARLES</u> Middle <u>EDWARD</u> Last <u>HOLLOWAY</u> | | | | 4. DATE OF DEATH
Month <u>MAR.</u> Day <u>7</u> Year <u>1961</u> | | | |
| 5. SEX
<u>MALE</u> | | 6. COLOR OR RACE
<u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>MAY 4, 1860</u> | |
| 9. AGE (In years lost birthday)
<u>100</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>FARMER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>RETIRED</u> | | 11. BIRTHPLACE (State or foreign country)
<u>HARFORD Co. MD.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>CHARLES A. HOLLOWAY</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>MARGARET GALLOP</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>—</u> | | | | 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT
<u>Mrs. Trudwell Gilbert Aberdeen, Md. R.D. 3</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bacterial pneumonia</u>
491X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>MAR 3</u> 19 <u>61</u> , to <u>MAR 7</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>MAR 7</u> 19 <u>61</u> , and that death occurred at <u>1:30</u> A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Dudley Phillips MD</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>3/10/61</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dudley Phillips MD</u> | | | | 22d. ADDRESS
<u>Darlington, Md</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>MAR 11, 1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>MT. ZION CEM.</u> | | 23d. LOCATION (City, town, or county) (State)
<u>HARFORD Co. MD</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>R. Madison Mitchell</u> | | | | ADDRESS
<u>Harold's Grove</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAR 14 '61</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Thara</u> | | | |

1311

CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03150

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
b. STATE <u>MD</u> c. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Harre-de-Grace</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>28 Aberdeen</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Harford Memorial Hospital</u> | | d. STREET ADDRESS
<u>1634 Shirley Drive</u> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Vernon</u> Middle <u>E.</u> Last <u>Hon.</u> | | 4. DATE OF DEATH
Month <u>3</u> Day <u>5</u> Year <u>1961</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>12/6/1914</u> |
| 9. AGE (In years last birthday)
<u>46</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Engineer (ord) Govt. App. wd</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Kentucky</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Hon. Pryor</u> | | 14. MOTHER'S MAIDEN NAME
<u>Leona Kendal</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u> </u> | |
| 17. INFORMANT
<u>Mary R. Hon. 634 Shirley Dr. Abd, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u>
331X DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Acute Vascular Hypertension</u>
(c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>
INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 5, 1961</u> to <u>March 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 5, 1961</u> , and that death occurred at <u>3:20 P.</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Gunther D. Hirsch</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>GUNTHER D. HIRSCH</u> | | 22d. ADDRESS
<u>HARRE DE GRACE, MARYLAND</u> | |
| 23a. BURIAL CREMATION, (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>3/7/1961</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Riverside Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Riverside Indiana</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>John G. Sarring - Aberdeen, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAR 8 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Arthur D. Fraser</u> | | 25c. REGISTRAR'S NAME | |

2016

535

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3163

CERTIFICATE OF DEATH

03151

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>HARFORD</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>
c. LENGTH OF STAY IN 1b <u>19 hrs</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>525 Fountain St. 24</u>
d. STREET ADDRESS <u>HAVRE DE GRACE</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>DONALD B. INMAN</u> | | 4. DATE OF DEATH
Month <u>March</u> Day <u>11</u> Year <u>1961</u> | | 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>White</u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>2/10/1879</u>
9. AGE (In years last birthday) <u>82</u> yrs. 10. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>
11. BIRTHPLACE (County & State, or foreign country) <u>N. Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>James R. Inman</u>
14. MOTHER'S MAIDEN NAME <u>Minanza Means</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>W.W. I</u>
16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Mr. India P. Inman</u>
Address <u>525 Fountain St. Havre de Grace, Md.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RUPTURED ANEURYSM ABDOMINAL AORTA</u>
DUE TO (b) <u>ARTERIOSCLEROSIS</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3-10</u> , 19 <u>61</u> , to <u>3-11</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>MARCH 11</u> , 19 <u>61</u> , and that death occurred at <u>10 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>D. Hirsch</u> 22b. DATE SIGNED <u>3-11-1961</u>
22c. PHYSICIAN'S NAME (Type) <u>GUNTHER D. HIRSCH</u>
22d. ADDRESS <u>HAVRE DE GRACE, MARYLAND</u> | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/14/61</u> 23b. DATE THEREOF <u>Angel Hill</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Havre de Grace, Md.</u> 23d. LOCATION (City, town or county) (State) _____ | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Princeton B. Hirsch</u> 25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>
Address <u>Havre de Grace, Md.</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>
DATE <u>MAR 16 '61</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03152

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY HARFORD
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HARFORD
c. LENGTH OF STAY IN lb 3 hrs 50 min
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HARFORD MEMORIAL HOSPITAL R.D. 2 Box 158 | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND
b. COUNTY HARFORD
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BEL AIR
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) CYRIL | | First Middle Last KOTRAS | | 4. DATE OF DEATH
Month Day Year MAR 10 1961 | | 9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov. 22, 1893 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer (Ret) | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. | | 11. BIRTHPLACE (County & State, or foreign country) CZECHOSLOVAKIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME IGNATZ KOTRAS | | | | 14. MOTHER'S MAIDEN NAME MAXI MILLIANA | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Address Edward Kotras, R.D. 2, Bel Air, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
420.1 DUE TO Coronary Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary Atherosclerosis
DUE TO (c) none
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) none | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 hrs
8 hrs
2 1/2 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 19 1961 to March 10 1961 that (I) (we) last saw the deceased alive on March 10 1961 and that death occurred at 3:50 PM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE L. Ralph Harty M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 3/10/61 | |
| 22c. PHYSICIAN'S NAME (Type) L. Ralph Harty | | | | 22d. ADDRESS Churchville Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 3/13/61 | | 23c. NAME OF CEMETERY OR CREMATORY St Francis Cemetery | | 23d. LOCATION (City, town or county) (State) Abingdon, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring | | | | Tarring Funeral Home Aberdeen, Md. | | 25a. REC'D BY REGISTRAR MAR 13 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Evans | |

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Inspector (P.S.) F.S. Govt.

Edward House, P.O. S. 541, No.

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|-------------------------------|---------------------------------------|---|--|--|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 3165 03153 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>
c. LENGTH OF STAY IN 1b <u>1 hour</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hosp.</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Harford</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Edgewood</u>
d. STREET ADDRESS <u>1</u> | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Raymond Woodrow Kregar</u> | | | | | | 4. DATE OF DEATH
Month <u>3</u> Day <u>4</u> Year <u>1961</u> | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Dec. 25, 1913</u> | | 9. AGE (In years last birthday) <u>47</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Expeditor</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Missle</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Joseph Kregar</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rosetta Jones Kregar</u> | | | | Address <u>Edgewood R.D., Md.,</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>217-05-2010</u> | | 17. INFORMANT <u>Gladys L. Kregar</u> | | | | Interval Between Onset and Death <u>2 hours</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute CORONARY OCCLUSION</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO <u> </u>
(c) DUE TO <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| MEDICAL CERTIFICATION
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Gunther D. Hirsch</u> M.D. | | | | | | 22b. DATE SIGNED <u>3-4-61</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>GUNTHER D. HIRSCH</u> | | | | | | 22d. ADDRESS <u>421 CONGRESS AV. HARRE DE GRACE</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE THEREOF <u>Mar. 7, 1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u> | | | 23d. LOCATION (City, town or county) (State) <u>Bel Air, Harford, Md.,</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McCombs Jr</u> | | | | | | ADDRESS <u>Abingdon, Maryland.</u> | | 25a. REC'D BY REGISTRAR <u>MAR 7 '61</u> | | 25b. REGISTRAR'S SIGNATURE <u> </u> | |

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Dec. 22, 1973

Missile

Explosion

Logwood R.D., Md.

117-02-2018 Gladys A. Knepper

no

Bel Air, Harford, Md.

Bel Air Memorial Gardens

Bel Air, Md.

Bel Air, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3166

03154

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>HARFORD</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u>
c. LENGTH OF STAY IN 1b <u>10 DAYS</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u> | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>MARYLAND</u>
b. COUNTY <u>HARFORD</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN Rural #1</u>
d. STREET ADDRESS <u>Box 175</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>MATILDA</u> Middle <u>ANN</u> Last <u>LONG</u> | | 4. DATE OF DEATH
Month <u>MARCH</u> Day <u>13</u> Year <u>1961</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 6th / 1898</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u> |
| 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>CHARLES SPIES</u> | | 14. MOTHER'S MAIDEN NAME
<u>BARBARA NOVANTY</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-12-0207</u> | |
| 17. INFORMANT
<u>Randell P. Long - Box 175 Aberdeen Md. #1.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) <u>450.0</u> DUE TO <u>Generalized circulatory failure</u>
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Thrombosis of mesenteric artery</u>
(c) <u>Generalized arteriosclerosis</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
<u>Diabetes mellitus</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. <u>19</u> p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1947</u> to <u>3-13-61</u> , that (I) (we) last saw the deceased alive on <u>3-13-61</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Peter P. Rodman</u> | | 22b. DATE SIGNED
<u>3-13-61</u> | 22c. PHYSICIAN'S NAME (Type)
<u>Peter P. Rodman, M.D.</u> |
| 22d. ADDRESS
<u>8 Low St., Aberdeen, Md.</u> | | 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>3/17/61</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Francis Cemetery</u> | 23d. LOCATION (City, town or county) (State)
<u>Aberdeen, Maryland</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>John E. Garry - Aberdeen, Maryland</u> | | 25. REC'D BY REGISTRAR
<u>MAR 20 '61</u> | |
| 25a. ADDRESS | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

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1917-18-19

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1917-18-19

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT. M X I 2

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|---|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 3167 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 03155 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>
c. LENGTH OF STAY IN 1b <u>MARYLAND</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Chesapeake Road</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MD</u>
b. COUNTY <u>Harford</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>
d. STREET ADDRESS <u>Chesapeake Road</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Arthur Leon Lufkin</u> | | 4. DATE OF DEATH <u>March 8</u> 19 <u>61</u> | | 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Cutter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Factory</u> | | 11. BIRTHPLACE (State or foreign country) <u>New Hampshire</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Frank Lufkin</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Eva Reed</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>Navy WW-1 003-01-4526</u> | | 17. INFORMANT <u>James A. Lufkin</u> | | Address <u>Chesapeake Rd. Aberdeen, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>25W L. Chest</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>976X</u>
(b) <u>976X</u>
DUE TO
(c) <u>976X</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>~</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot Self with 12 Ga. Shot Gun</u> | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>10:30</u> p.m. <u>3-8</u> 19 <u>61</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Aberdeen</u> (County) <u>Harford</u> (State) <u>MD</u> | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> | | M.D. <u>Gerald C Palmer, MD</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-8-61</u> | | | |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer, MD</u> | | Address (Street, city, town, or county) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 22b. DATE THEREOF <u>3/9/1961</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Acworth Cemetery</u> | | 22d. LOCATION (City, town, or country) (State) <u>Acworth New Hampshire</u> | | | |
| 23. FUNERAL DIRECTOR <u>John G. Farring - Aberdeen, Md.</u> | | ADDRESS | | 24a. REC'D BY REGISTRAR <u>Mar 13 '61</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen | | | | | | | | | | c. LENGTH OF STAY IN 1b 15 Yrs | | | | | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 28 Aberdeen | | | | | | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen Proving Ground, Md | | | | | | | | | | d. STREET ADDRESS 1 6 West Market | | | | | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last JOHN ANDREWS MACLAUGHLIN | | | | | | | | | | 4. DATE OF DEATH Month Day Year March 18 19 61 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. SEX Male | | | 6. COLOR OR RACE White | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH April 20, 1890 | | | 9. AGE (In years lost birthday) 70 yrs. | | | IF UNDER 1 YEAR Months Days | | | IF UNDER 24 HRS. Hours Min. | | | | | | | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier-Colonel (Ret) | | | | | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY US Army Retired | | | | | | | | | | 11. BIRTHPLACE (State or foreign country) New Jersey | | | | | | | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | |
| 13. FATHER'S NAME John Thomson MacLaughlin | | | | | | | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Dyer | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unknown) Yes | | | | | | | | | | 16. SOCIAL SECURITY NO. 20 Apr 1950 215-32-9639 | | | | | | | | | | 17. INFORMANT Charles Andrews MacLaughlin (Son) Same as 2) | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 443X Cerebral hemorrhage DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cerebral vascular disease DUE TO
(c) Hypertensive cardiovascular disease | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 13 days
Not Known
More than 11 Years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | | | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | | 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that (I) MacLaughlin attended the deceased from February 2, 1960, to 18 March 1961, that (I) was last saw the deceased alive on March 17, 1961, and that death occurred at 11:54 AM, from the causes and on the date stated above. | | | | | | | | | | 22a. SIGNATURE J. A. Grossman | | | | | | | | | | 22b. DATE SIGNED March 18, 1961 | | | | | | | | | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) J. A. GROSSMAN Capt MC | | | | | | | | | | 22d. ADDRESS US Army Hospital Aberdeen Proving Ground, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE THEREOF Mar. 20, 1961 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Post Cemetery | | | | | | | | | | 23d. LOCATION (City, town, or county) (State) Army Chemical Center, Md., | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Howard K. Thompson | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE MAR 21 '61 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | | | | | | | | |

• **Table**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3169

CERTIFICATE OF DEATH

Reg. Dist. No. 13157

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Harford</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Aberdeen #2</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Aberdeen Rural #2</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>Gilbert Road</i> | | e. STREET ADDRESS
<i>Bethel-Aberdeen Road</i> | |
| 3. NAME OF DECEASED
(Type or print)
First <i>Thelma</i> Middle <i>Sybil</i> Last <i>McLaren</i> | | 4. DATE OF DEATH
Month <i>3</i> Day <i>21</i> Year <i>1961</i> | |
| 5. SEX
<i>Female</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>June 29-1901</i> |
| 9. AGE (In years last birthday)
<i>59</i> yrs. | | 10. IF UNDER 1 YEAR
Months _____ Days _____ Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Home</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Carroll T. Hughes</i> | | 14. MOTHER'S MAIDEN NAME
<i>Lucie U. Greenland</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>213-38-6120</i> | |
| 17. INFORMANT
<i>Mrs Willard Pyle = Aberdeen Rural #2 Rd.</i> | | Address _____ | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Cardiac arrest</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary occlusion</i>
(c) <i>Coronary arteriosclerosis</i>
INTERVAL BETWEEN ONSET AND DEATH
<i>Terminal</i>
<i>1/2 hour</i>
<i>4 yr.</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arterial hypertension; Cerebral arteriosclerosis</i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>12-28-</i> , 19 <i>60</i> , to <i>3-21-</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>12-28-</i> , 19 <i>60</i> , and that death occurred at <i>1:30 P</i> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<i>Peter P. Rodman</i> | | ADDRESS (Street, city or town, state) <i>8 Low St - Aberdeen, Md.</i> | |
| DATE SIGNED
<i>3-23-61</i> | | | |
| PHYSICIAN'S NAME (Type)
<i>Peter P. Rodman, M.D.</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 22b. DATE THEREOF
<i>3/24/1961</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<i>Smith Chapel Cemetery</i> | | 22d. LOCATION (City, town, or county) (State)
<i>Aberdeen Rural #2 Rd</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>John G. Farring - Aberdeen, Md.</i> | | ADDRESS _____ | |
| 24a. REC'D BY REGISTRAR
DATE <i>MAR 27 '61</i> | | 24b. REGISTRAR'S SIGNATURE
<i>Charles S. Hume</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---|---|--|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 3170 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 03158 | | | | | | | | | |
| 1. PLACE OF DEATH
e. COUNTY HARFORD
M
MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY HARFORD | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Edgewood | | | c. LENGTH OF STAY IN 1b
Edgewood | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Edgewood | | | d. STREET ADDRESS
Edgewood Road | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Edgewood Road | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print) | | First LESTER | | Middle F. | | Last MAHLEN | | 4. DATE OF DEATH
Month March Day 24 Year 1961 | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Oct. 12, 1907 | | 9. AGE (In years last birthday) 53 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Soldier | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S.A. | | 11. BIRTHPLACE (State or foreign country)
Minnesota | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Fred. Mahlen | | | | | 14. MOTHER'S MAIDEN NAME
Mae Wellshinger | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | | | | 16. SOCIAL SECURITY NO. 123-073-623 | | | | |
| 17. INFORMANT Official U.S. Army Records | | | | | Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction | | | | | | | | | |
| DUE TO 420.1 | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease | | | | | | | | | |
| DUE TO (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Partial | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE Charles S. Petty | | | | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) Charles S. Petty, M.D. | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| Address (Street, city, town, or county) | | | | | DATE SIGNED 3/25/61 | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL | | 22b. DATE THEREOF
3-28-61 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | | 22d. LOCATION (City, town, or country) (State)
Arlington, Va | | |
| 23. FUNERAL DIRECTOR
ADDRESS
Wm. Cook-Blight, Inc., 6009 Harford Road | | | | | | 24e. REC'D BY REGISTRAR
DATE MAR 28 '61 | | 24f. REGISTRAR'S SIGNATURE
Arthur L. House | |

MEDICAL CERTIFICATION

(M)

(I)

yes 10-1-8 to 12-1-8
Fred. Hansen
New Hollister

Testimonial card on soldier's discharge

Charles E. Jesty, Jr.

Wm. Cook-211-21, Inc., 6002 Hartland Road
Arlington, Virginia
22204

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3171

04345

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>HARFORD</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAURDE GRACE</u> | | | | c. LENGTH OF STAY IN <u>20 hr</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD Memorial</u> | | | | d. STREET ADDRESS <u>1816 Locust</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>MALLORY</u> | | | | 4. DATE OF DEATH <u>March 25 1961</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Colored</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>March 24, 1961</u> | |
| 9. AGE (In years last birthday) <u>2</u> yrs. | | IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> | | IF UNDER 24 HRS. Hours <u>2</u> Min. <u>2</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>MD</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME <u>Goldie Arcina MALLORY</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Address <u>Mother - 816 Locust St. HAURDE GRACE</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Subdural Hemorrhage</u>
760.8 DUE TO <u>Breath Delivery</u>
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>Breath Delivery</u>
(c) <u>Breath Delivery</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour a.m. _____ p.m. _____ | | Month, Day, Year
_____ 19____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 24, 1961</u> to <u>March 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 25, 1961</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | | | 22b. DATE SIGNED _____ | | | |
| 22c. PHYSICIAN'S NAME (Type) _____ | | | | 22d. ADDRESS _____ | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 23b. DATE THEREOF <u>3/25/61</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>HARFORD Memorial Hospital</u> | | 23d. LOCATION (City, town or county) <u>HAURDE GRACE, MD</u> (State) _____ | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Kelly</u> ADDRESS <u>Administrator</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>MAY 5 '61</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u> | |

-2071163XV5

0337

CHINESE UNIVERSITY

1951

(C)
(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3172

CERTIFICATE OF DEATH

Reg. Dist. No.

03159

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Aberdeen | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Aberdeen | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
116 Rigdon Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First HENRIETTA Middle W. Last McFADDEN | | | | 4. DATE OF DEATH
Month March Day 8 Year 1961 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Feb. 16, 1918 | |
| 9. AGE (In years last birthday)
43 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bank Teller | | 10b. KIND OF BUSINESS OR INDUSTRY
Bank | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William Harry Webster | | | | 14. MOTHER'S MAIDEN NAME
Mary Frances Snodgrass | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
217-24-9251 | | 17. INFORMANT
E.L. McFadden, Aberdeen, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Inanition
DUE TO (b) Metastatic Carcinoma of breast
DUE TO (c) 170X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 month
1 year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11-22-61 to 3-8-61 , that I last saw the deceased alive on 3-8-61 , 19 61 , and that death occurred at 5:45 PM from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 617 W. Bel Air Ave. Aberdeen, Md.
DATE SIGNED 3/10/61 | | | | | | | |
| ACTUAL SIGNATURE Barry J. Plunkett Jr. M.D. | | | | DATE SIGNED 3/10/61 | | | |
| PHYSICIAN'S NAME (Type) Barry J. Plunkett Jr. M.D. | | | | ADDRESS Aberdeen, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3/11/61 | | 22c. NAME OF CEMETERY OR CREMATORY
Bel Air Memorial Gardens, Bel Air, Maryland | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John G. Tarring
Aberdeen, Md. | | | | 24a. REC'D BY REGISTRAR
MAR 13 '61 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | |

John G. Tarring

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained from the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

1175

| | | | |
|------------------------|--|------------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| JAMES H. BROWN | | JAN 15 1950 | |
| AGE | | SEX | |
| 65 | | M | |
| RACE | | EDUCATION | |
| W | | H | |
| MARRIED | | OCCUPATION | |
| Y | | C | |
| PLACE OF BIRTH | | PLACE OF DEATH | |
| BALTIMORE, MD | | BALTIMORE, MD | |
| CAUSE OF DEATH | | MANNER OF DEATH | |
| HEART DISEASE | | NATURAL | |
| IMMEDIATE CAUSE | | FURTHER INFORMATION | |
| CORONARY THROMBOSIS | | NO OTHER INFORMATION | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | |
| J. H. BROWN | | J. H. BROWN | |
| DATE | | DATE | |
| JAN 15 1950 | | JAN 15 1950 | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03160

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Hartford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>
d. STREET ADDRESS <u>314 Lafayette</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>
c. LENGTH OF STAY in 1b <u>13 days</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>
f. STREET ADDRESS <u>314 Lafayette</u> | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Shirley Wilford McFarland</u> | | | | 4. DATE OF DEATH
Month <u>3</u> Day <u>5</u> Year <u>1961</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH
<u>OCT. 16 1912</u> | | 9. AGE (In years last birthday) <u>48</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | | |
| 11. IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Premix MAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>COCA COLA CO.</u> | | | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Va.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>Edward McFarland</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Minnie Riley</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u> </u> | | 16. SOCIAL SECURITY NO.
<u>215-14-1827</u> | | | |
| 17. INFORMANT
Address <u>HARRE-DE-GRACE MD.</u>
<u>Georgia McFarland</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carcinoma lung</u>
DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>1 yr</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u> </u> p.m. <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/1/1961</u> to <u>3/5/1961</u> that (I) (we) last saw the deceased alive on <u>3/5/1961</u> and that death occurred at <u>5:35 PM</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Irvin L. Wachsman M.D.</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>3/5/61</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>IRVIN L. WACHSMAN</u> | | 22d. ADDRESS
<u>407 S. UNION AVE. HARRE-DE-GRACE MD.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>MAR 8 1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>BEL AIR MEMORIAL GARDEN</u> | | | |
| 23d. LOCATION (City, town or county)
<u>HARTFORD</u> | | (State)
<u>MD</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAR 7 '61</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>R. Madison Mitchell</u> | | ADDRESS
<u>Harre-de-Grace MD</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kneiss</u> | | | |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03160

03160



[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be obtained by the attending physician or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

Richard Lininger Funeral Home
Curwensville, Pennsylvania

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3174

Item 4 Film G284 4/4/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

03161

| | | | |
|--|------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bel Air (Rural) | | c. LENGTH OF STAY IN 1b
2 months | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Havre de Grace | | 24 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Harford Convalescent Home | | d. STREET ADDRESS
620 Fountain Street | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
Vada First B. Middle Miller Last | | 4. DATE OF DEATH
March 27 19 61 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 23, 1883 |
| 9. AGE (In years last birthday)
77 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Ansonville Pa | | 12. CITIZEN OF WHAT COUNTRY?
US | |
| 13. FATHER'S NAME
George W. Bollinger | | 14. MOTHER'S MAIDEN NAME
Mollorie Mays | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
190-03-6880 | |
| 17. INFORMANT (Son)
Mr. Fred E. Miller | | 620 Fountain St.
Havre de Grace, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic CV disease
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3-14 , 19 61 , to 3-27 , 19 61 , that I last saw the deceased alive on 3-25 , 19 61 , and that death occurred at 4:30 P. M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Gerald C Palmer | | ADDRESS (Street, city or town, state)
Bel Air, Md. | |
| PHYSICIAN'S NAME (Type)
Gerald C. Palmer M.D. | | DATE SIGNED
3-28-61 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Mar. 30, 1961 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Fruit Hill Cem. | | 22d. LOCATION (City or town, county, state)
Jourdain Twp. Clearfield Co. Pennsylvania | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Joseph W. Foster | | 24a. REC'D BY REGISTRAR
W. Broadway & Williams | |
| 24b. REGISTRAR'S SIGNATURE
Bel Air, Maryland | | DATE
MAR 30 '61 | |

1
FOR STATE
HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3175 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03162

| | | | | | | | |
|---|--|-----------------------------|--|---|--|----------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <u>Md</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harrods Creek</u> | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harrods Creek</u> | | | |
| c. LENGTH OF STAY in 1b <u>40 hrs.</u> | | | | d. STREET ADDRESS <u>1 Robin Hood Road</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Stella Marie Moor</u> | | | | 4. DATE OF DEATH Month Day Year <u>March 26 19 61</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2/3/1936</u> | |
| 9. AGE (In years last birthday) <u>35</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Club</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Metals</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>N. C.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>N. C.</u> | | | |
| 13. FATHER'S NAME <u>Lee Stanley</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Hughes</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | | |
| 17. INFORMANT <u>Carl Moore</u> | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Fracture skull</u>
823X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture skull</u>
DUE TO
(c) <u>Fracture skull</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - ran off road</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour :m: p.m. <u>3/24 19 61</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Robin Hood Road</u> | | | | 20f. (City or town) (County) (State) <u>Harrods Creek Harford Md.</u> | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Gerald E Palmer</u> | | | | CHIEF MEDICAL EXAMINER <u>3-26-61</u> | | | |
| EXAMINER'S NAME (Type) <u>Gerald E Palmer - md</u> | | | | DEPUTY MEDICAL EXAMINER <u>Bel Air, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/29/61</u> | | | | 22b. DATE THEREOF <u>3/29/61</u> | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial</u> | | | | 22d. LOCATION (city, town, or country) (State) <u>Bel Air Md</u> | | | |
| 23. FUNERAL DIRECTOR <u>Funerary Co., Harrods Creek Md.</u> | | | | 24e. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> | | | |
| 24b. ADDRESS <u>Harrods Creek Md.</u> | | | | 24c. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

DATE

2175

ON DATE
IN THE DEPT.

(M)

(I)

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "A", "the", "and", "of" are visible.]

1 Page 4 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the attending physician or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. FOSTER FUNERAL HOME 1000 BROADWAY & WILLIAMS BEL AIR, MD. VS A15 (4) 15M 10/57 3176 03163 Reg. Dist. No. 1. PLACE OF DEATH a. COUNTY Harford MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford 3. NAME OF DECEASED (Type or print) First Middle Last Maxwell Carl Newman 4. DATE OF DEATH Month Day Year March 31, 19 61 5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH Nov. 1, 1885 9. AGE (In years, month, days, hours, min.) 75 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. of Hull Const. 10b. KIND OF BUSINESS OR INDUSTRY Steel-Shipyard 11. BIRTHPLACE (State or foreign country) Wilmington, Delaware 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME Henry H. Newman 14. MOTHER'S MAIDEN NAME Katherine C. Heinz 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 216-10-4120 17. INFORMANT (Son) Henry C. Newman 102 Chatham Place Bel Air, Maryland 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION DUE TO (b) CORONARY SCLEROSIS DUE TO (c) ARTERIO SCLEROSIS, ADVANCED INTERVAL BETWEEN ONSET AND DEATH 1/2 HR. 3 MO 2 YRS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 While ☐ Not while ☐ of work ☐ of work ☐ 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from APR. 15, 1960, to MAR 31, 1961, that I last saw the deceased alive on 15 MAR 1961, and that death occurred at 11:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 20 APR 61 ACTUAL SIGNATURE H. P. Sidwell M.D. PHYSICIAN'S NAME (Type) H. P. Sidwell M.D. Franklin Street, Bel Air, Md. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4/3/61 22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery 22d. LOCATION (City, town, or county) (State) Baltimore Maryland 23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster W. Broadway & Williams ST. Bel Air, Maryland 24a. REC'D BY REGISTRAR DATE APR 3 1961 24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3177

CERTIFICATE OF DEATH

03164

| | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Hartford</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Harpe-de-Grace</u> c. LENGTH OF STAY in lb <u>4 days</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Hartford Memorial Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Kansas</u> b. COUNTY <u>✓</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Scott City</u>
d. STREET ADDRESS <u>54x-3</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>George Graham Nonnamaker</u> | | 4. DATE OF DEATH
Month <u>3</u> Day <u>11</u> Year <u>1961</u> | | 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>July 8 1889</u> | | 9. AGE (In years last birthday) <u>71</u> yrs.
IF UNDER 1 YEAR: Months <u>7</u> Days <u>11</u> Hours <u>19</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Riding School Owner</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Indiana</u> | | | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Indiana</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Frank Nonnamaker</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Lagonyi Litzzenberger</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or date of service) | | | | 16. SOCIAL SECURITY NO.
<u>George Nonnamaker</u> | | | | 17. INFORMANT
<u>George Nonnamaker</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>
DUE TO <u>420.1</u>
Conditions, if any, which gave rise to immediate cause (b) _____
(a), stating the underlying cause last. DUE TO (c) _____ | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 MINUTE</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED
White <input type="checkbox"/> Not White <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) (this Hospital) attended the deceased from <u>March 1, 1961</u> to <u>March 11, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 11, 1961</u> , and that death occurred at <u>7:30</u> a.m. from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Dudley Phillips</u> M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dudley Phillips MD</u> | | | | | | 22d. ADDRESS
<u>Darlington, Md</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>March 12 1961</u> | | | | 23b. DATE THEREOF | | | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Scott City</u> | | | | 23d. LOCATION (City, town or county)
<u>Kansas</u> | |
| 24 FUNERAL DIRECTOR'S SIGNATURE
<u>A S Bailey</u> | | | | | | ADDRESS
<u>Darlington Md</u> | | | | 25a. RECORD BY REGISTRAR
DATE <u>MAR 15 '61</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

TO HO...AL OR...NDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

5516

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

3178

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03165

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Harford</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE <i>md</i> b. COUNTY <i>Harford</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Harre-de-Grace</i> | | c. LENGTH OF STAY IN 1b
<i>13 hrs.</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>Harford Memorial Hospital</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Cibingdon</i> | |
| 3. NAME OF DECEASED
(Type or print)
First <i>Baby</i> Middle <i>Girl</i> Last <i>Peaker</i> | | 4. DATE OF DEATH
Month <i>3</i> Day <i>31</i> Year <i>1961</i> | |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>Negro</i> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>3-31-61</i> | |
| 9. AGE (In years last birthday)
<i>13</i> | | IF UNDER 1 YEAR
Months <i>13</i> Days <i>13</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<i>HARFORD CO. MARYLAND</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<i>Lewis W. Jackson</i> | | 14. MOTHER'S MAIDEN NAME
<i>Daisy Parker</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes give number or date of service) | |
| 17. INFORMANT
Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pulmonary atelectasis</i>
762.5 DUE TO
Conditions, if any, which gave rise to immediate cause (b) <i>Immaturity</i>
(a), stating the underlying cause last. DUE TO (c) <i>Premature labor</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<i>none</i> | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <i>19</i> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>7:30</i> A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Wm. M. Keen</i> M.D. | | 22b. DATE SIGNED
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>CREMATION</i> | | 23b. DATE THEREOF
<i>4-1-61</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<i>Harford Memorial Hosp</i> | | 23d. LOCATION (City, town or county) (State)
<i>Harre de Grace Md</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Harry A. Zully</i> administrator | | 25a. REC'D BY REGISTRAR
DATE <i>APR 7 '61</i> | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur E. Kraus</i> | |

2071253XVO

05180

0518

(M)

(Y)

1
FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3175 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03166

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|---------------------------|--|--|--|-----------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Norrisville</u> | | c. LENGTH OF STAY IN 1b <u>10 YRS.</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Norrisville</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | d. STREET ADDRESS <u>Island Branch Road</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Claude S. Price</u> | | | | 4. DATE OF DEATH <u>March 23</u> 19 <u>61</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT. 15, 1904</u> | 9. AGE (In years last birthday) <u>56</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u> | | 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>JEFF PRICE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>JOSSIE ST JOHN</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>214-18-1068</u> | | 17. INFORMANT <u>Mrs Henry Alloway, Farm House Pa</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>G S W Cerebrum</u>
976X DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with shotgun</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>4 3-23-61</u> Hour a.m. <u>3</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Norrisville</u> (County) <u>Harford</u> (State) <u>MD</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> | | M.D. | | CHIEF MEDICAL EXAMINER <u>Bel Air, Md</u> | | DATE SIGNED <u>3-23-61</u> | |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3-25-61</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>BELAIR MEM. GARDENS BELAIR HARFORD CO., MD.</u> | | 22d. LOCATION (City, town, or country) (State) | |
| 23. FUNERAL DIRECTOR <u>Bennett W. Osburn, Stewartstown Pa</u> ADDRESS | | | | 24a. REC'D BY REGISTRAR <u>DAVID 27 '61</u> | | 24b. REGISTRAR'S SIGNATURE <u>Andrew L. Kline</u> | |

05106

05106

(M)

(I)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information required by the law. The law requires that the death certificate be executed within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3180

CERTIFICATE OF DEATH 4 transcripts

Reg. Dist. No. 03167

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bel Air | | c. LENGTH OF STAY IN 1b
Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Vale Road | | d. STREET ADDRESS
Vale Road | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First James J. Middle Richardson Last | | 4. DATE OF DEATH
Month March Day 9 Year 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 8, 1901 |
| 9. AGE (In years last birthday)
59 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Reg. Pharmacist | | 10b. KIND OF BUSINESS OR INDUSTRY
Drug | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John S. Richardson | | 14. MOTHER'S MAIDEN NAME
Elizabeth K. Hardesty | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
215-05-0773 | |
| 17. INFORMANT
Mrs. Martha E. Richardson, Bel Air, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO
(c) Chronic Cardio-vascular Disease | | INTERVAL BETWEEN ONSET AND DEATH
10 hours
? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Emphysema | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 8, 1960 , to March 9, 1961 , that I last saw the deceased alive on March 9, 1961 , and that death occurred at 10:30 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Willard P. Hudson | | ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED March 10, 1961 | |
| PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3/12/1961 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Rock Spring | | 22d. LOCATION (City, town, or county) (State)
Bel Air Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Joseph W. Foster
W. Broadway + Williams St.
Bel Air, Maryland | | 24a. REC'D BY REGISTRAR
DATE MAR 13 '61 | |
| 24b. REGISTRAR'S SIGNATURE
Charles L. Hays | | | |

CERTIFICATE OF DEATH

Reg. Dist. No. 03168

3181

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural-Whiteford | | c. LENGTH OF STAY IN 1b
11 mo. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Little Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JAMES Middle FRANKLIN Last SIMPERS | | 4. DATE OF DEATH
Month March Day 15 Year 19 61 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Mar. 23, 1960 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
----- | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | 9. AGE (In years last birthday)
yrs. 11 Months 11 Days 11 Hours 11 Min. |
| 11. BIRTHPLACE (State or foreign country)
Harford Co., Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Allen R. Simpers | | 14. MOTHER'S MAIDEN NAME
Myrtle Combs | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
-- -- | | 16. SOCIAL SECURITY NO.
----- | |
| 17. INFORMANT
Allen R. Simpers, Whiteford, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Broncho pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH
2 days | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from March 14, 1961 , to March 15, 1961 , that I last saw the deceased alive on March 14, 1961 , and that death occurred at 12 A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Delta, Penna.
DATE SIGNED 3/15/61
ACTUAL SIGNATURE Josiah A. Hunt M.D. Joel A. Hunt
PHYSICIAN'S NAME (Type) Josiah A. Hunt | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
Mar. 18, 1961 | 22c. NAME OF CEMETERY OR CREMATORY
Fellowship | 22d. LOCATION (City, town, or county) (State)
Fylesville, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John H. Hawkins
ADDRESS
Delta, Penna. | | 24a. REC'D BY REGISTRAR
DATE MAR 17 '61 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hume |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

- 2065 212 XV6

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3182

Item 14 Film G204 4/6/61 iwk

CERTIFICATE OF DEATH

03169

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY HARFORD
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE
c. LENGTH OF STAY IN 1b 1 hr 10 min
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HARFORD MEMORIAL | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MD
b. COUNTY HARFORD
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Whiteford
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
EMORY THOMAS SMITHSON
First Middle Last | | | | 4. DATE OF DEATH
MARCH 26 1961
Month Day Year | | | |
| 5. SEX MALE | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JAN. 6, 1880
Yrs. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) HARFORD CO. MD. | |
| 13. FATHER'S NAME THOMAS SMITHSON | | | | 14. MOTHER'S MAIDEN NAME unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 197-07-2932 | | 17. INFORMANT MRS. CHARLES MICHAEL BELAIR, MD.
Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) due to coronary thrombosis
(c) A.S.C.V.D.
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
1 day
? | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3/26 1961 to 3/26 1961 that (I) (we) last saw the deceased alive on MARCH 26 1961 , and that death occurred at 7:20 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Edward C. Loo, M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 3/27/61 | |
| 22c. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D. | | | | 22d. ADDRESS 211 N. Union Ave. Haure de Grace, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 3-29-61 | | 23c. NAME OF CEMETERY OR CREMATORY SLATEVILLE | | 23d. LOCATION (City, town or county) (State) DELTA, PA. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John H. Harbina, Delta, Pa. | | | | 25a. REC'D BY REGISTRAR APR 3 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Harris | |

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Mrs. Ingeborg Olsen

03170
6824 Owlshead Court
Brooklyn 20, N.Y.

3183

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH:
a. COUNTY Hartford
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hartford
c. LENGTH OF STAY in 1b 7 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Hartford Memorial Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MD
b. COUNTY Hartford
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air
d. STREET ADDRESS RT. #2
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Andrew Thompson | | 4. DATE OF DEATH
Month 3 Day 8 Year 1961 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 8, 1885 |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR
Months 7 Days 5 | IF UNDER 24 HRS.
Hours 5 Min. 00 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 11. BIRTHPLACE (County & State, or foreign country) Norway | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Uidal Thompson | | 14. MOTHER'S MAIDEN NAME Ingeborg Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 085-10-3370 | |
| 17. INFORMANT Othel Seymour | | Address RT #2 Bel Air, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 199X Sarcoma, metastatic lungs
Conditions, if any, which gave rise to immediate cause (b) Sarcoma - primary site undetermined
(c) 199X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tobac Pneumonia, st | | INTERVAL BETWEEN ONSET AND DEATH 3 wks. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour 19 e.m. p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from April 1950 to March 1961 , that (I) (we) last saw the deceased alive on March 1961 , and that death occurred at 6 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Ralph Horvitz | | 22b. DATE SIGNED March 9, 1961 | |
| 22c. PHYSICIAN'S NAME (Type) Ralph Horvitz | | 22d. ADDRESS Churchville Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Mar. 11, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens | 23d. LOCATION (City, town or county) (State) Bel Air, Hartford Co., Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster ADDRESS W. Broadway + Williams St Bel Air, Maryland | | 25a. REC'D BY REGISTRAR MAR 13 '61 | 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus |

MEDICAL CERTIFICATION

W. BROADWAY & WILLIAMS
BEL AIR, MD.

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

150

1883



[Faint, mostly illegible handwritten text, possibly a letter or document, with some visible words like "Dear Sir" and "Yours faithfully"]

1
FOR STATE
HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3184

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03171

| | | | | | |
|---|---|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>
c. LENGTH OF STAY IN 1b <u>14 DAYS</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u> | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MD</u>
b. COUNTY <u>Harford</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>
d. STREET ADDRESS <u>Chapel Road</u>
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <u>William Thompson</u> | | | 4. DATE OF DEATH <u>March 16</u> 19 <u>61</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 8, 1931</u> | 9. AGE (In years last birthday) <u>29</u> yrs. | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ROSE SALESMAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>SEAL TEST</u> | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>MILLARD H. THOMPSON</u> | | | 14. MOTHER'S MAIDEN NAME <u>ROSA BRADFORD</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> | | 16. SOCIAL SECURITY NO. <u>218-32-0585</u> | 17. INFORMANT <u>DORRIS J. THOMPSON</u> Address <u>HAVRE DE GRACE R.D. 2 MD</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolism</u>
904.9 DUE TO (b) <u>Phlebotrombosis R leg + thigh</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Fracture R fibula + Rupture ligaments R ankle</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Fell carrying case milk</u> | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>9</u> | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> | |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>3-17-61</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>MAR. 19, 1961</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>WESLEYAN CHAPEL CEM</u> | 22d. LOCATION (City, town, or country) <u>HARFORD Co.</u> | (State) <u>MD</u> | |
| 23. FUNERAL DIRECTOR <u>R. Madison Mitchell</u> | | | ADDRESS <u>Havre de Grace MD.</u> | | |
| 24a. REC'D BY REGISTRAR <u>DATE MAR 22 '61</u> | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | | |

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3184

FOR STATE
USE ONLY



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, WASHINGTON, D.C. 20492.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03172

3185

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>HARFORD</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL BELAIR</u>
c. LENGTH OF STAY IN 1b <u>1</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u>
b. COUNTY <u>HARFORD</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL BEL AIR</u>
d. STREET ADDRESS <u>1</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>HAZEL</u> Middle <u>S.</u> Last <u>WEBB</u> | | 4. DATE OF DEATH
Month <u>3</u> Day <u>29</u> Year <u>1961</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 16, 1891</u> |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | IF UNDER 24 HRS.
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>WILLIAM SMITH</u> | | 14. MOTHER'S MAIDEN NAME <u>MATTIE BOYLE</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>Joseph H Webb</u> Address <u>Bel Air Rd #1, Eud.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
260X DUE TO (b) <u>Aneurysmal C.V. Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>with hypertension</u>
DUE TO (c) <u>Decompressive Nucleotomy</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>12 hrs</u>
<u>8 yrs</u>
<u>12 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Hypertrophic Arteriosclerosis</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. <u>19</u>
p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
ot work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept 1940</u> to <u>March 1961</u> , that I last saw the deceased alive on <u>March 29, 1961</u> , and that death occurred at <u>6:05 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>J. Ralph Horkey</u> M.D. | | ADDRESS (Street, city or town, state) <u>Churchville Md</u> DATE SIGNED <u>3/29/61</u> | |
| PHYSICIAN'S NAME (Type) <u>J. Ralph Horkey MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>3-31-61</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>FAWN GROVE CEM.</u> | 22d. LOCATION (City, town, or county) (State) <u>FAWN GROVE, YORK CO., Pa.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth C. Cushman</u> ADDRESS <u>Stewartstown Pa.</u> | | 24a. REC'D BY REGISTRAR DATE <u>APR 4 '61</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | |

(M)

X

(I)

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the attending physician or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2182

DEATH
CONFIDENTIAL
RECORD

| | | | | | | | | | |
|------------------------|--|------------------------|--|------------------------|--|----------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | |
| John Doe | | Male | | 45 | | 1910 | | Chicago, Ill. | |
| Cause of Death | | Manner of Death | | Date of Death | | Place of Death | | Physician | |
| Heart Disease | | Natural | | 1955 | | Chicago, Ill. | | Dr. Smith | |
| Occupation | | Education | | Marital Status | | Previous Illnesses | | Signature of Registrar | |
| Teacher | | High School | | Married | | None | | [Signature] | |
| Signature of Physician | | Signature of Registrar | | Signature of Informant | | Signature of Witness | | Signature of Coroner | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3186

Items 1d, & 14 Film G284 4/6/61 iwk

03173

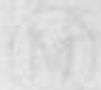
| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Illinois b. COUNTY Cook | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rural- Street | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Oak Park | |
| c. LENGTH OF STAY IN 1b
2 hrs. | | d. STREET ADDRESS
1159 South Grove Ave. | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
(Private home) of Paul Halsey, Jr. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Raymond Philip Weiss | | 4. DATE OF DEATH
March 25, 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
February 2, 1909 |
| 9. AGE (In years last birthday)
52 yrs. | | 10. IF UNDER 1 YEAR
Months 2 Days 2 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Electrician | | 10b. KIND OF BUSINESS OR INDUSTRY
Nashville, Ill. | |
| 11. BIRTHPLACE (County & State, or foreign country)
USA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
George Weiss | | 14. MOTHER'S MAIDEN NAME
Georgianna Beattie | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
320-10-6160 | |
| 17. INFORMANT
Mrs. Raymond Weiss | | Address
1159 S. Grove Ave. Oak Park, Illinois | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Coronary insufficiency
(a), stating the underlying cause last. DUE TO (c) 6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from March 25, 1961 to March 25, 1961 that (I) (we) last saw the deceased alive on March 25, 1961 and that death occurred at 6:30 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Donald A. Hunt M.D. | | 22b. DATE SIGNED
March 25, 1961 | |
| 22c. PHYSICIAN'S NAME (Type)
Donald A. Hunt M.D. | | 22d. ADDRESS
Delta, Pa. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | 23b. DATE THEREOF
Mar. 26, 1961 | 23c. NAME OF CEMETERY OR CREMATORY
Delta, Penna. | 23d. LOCATION (City, town or county) (State)
Chicago, Illinois |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John H. Harkins | | 25a. REC'D BY REGISTRAR
APR 3 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Charles S. Kraus | | | |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03133

03133



Book

Book

Vol. 2

Vol. 2

Vol. 2

1880: South Street, New York

1880: South Street, New York

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2 1/2 km
Circled

Government Commission
Government Commission

March 27 1961

March 27 1961

Delta, Pa.

James A. Hunt, MD
James A. Hunt, MD

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3187

CERTIFICATE OF DEATH

Reg. Dist. No.

03174

| | | | | | | | |
|---|----------------------------------|---|--|---|---|--|------------------|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Pylesville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Pylesville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print)
First Neva Middle J. Last Whiteford | | | | 4. DATE OF DEATH
Month March Day 25 Year 1961 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 19, 1883 | 9. AGE (In years last birthday)
78 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
own home | | 11. BIRTHPLACE (State or foreign country)
Harford Co., Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Howard Streett | | | | 14. MOTHER'S MAIDEN NAME
Ellen Jane Campbell | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mrs. Frank Linkous, Pylesville RD, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
5 days | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from March 20, 1961 , to March 25, 1961 , that I last saw the deceased alive on March 24, 1961 , and that death occurred at 6 A. M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Edward W. Hyson M.D. | | | | ADDRESS (Street, city or town, state) Fawn Grove, Penna. DATE SIGNED 3/25/61 | | | |
| PHYSICIAN'S NAME (Type) Edward W. Hyson Fawn Grove, Penna. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3-28-61 | | 22c. NAME OF CEMETERY OR CREMATORY
Fawn Grove Meth. Cem. | | 22d. LOCATION (City, town, or county) (State)
Fawn Grove, York Co., Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Kenneth W. Buchanan | | | | ADDRESS
Stewartstown, Penna. | | 24a. REC'D BY REGISTRAR
DATE MAR 28 '61 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Huns | | | |

MEDICAL CERTIFICATION

Page 4
Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1887

(M)

| | | | |
|--------------------------------|--|------------------------|--|
| PLACE IN STATE OF MARYLAND | | COUNTY OF BALTIMORE | |
| CITY OF BALTIMORE | | WARD OF BALTIMORE | |
| NAME OF DECEASED | | AGE | |
| SEX | | RACE | |
| DATE OF DEATH | | PLACE OF DEATH | |
| CAUSE OF DEATH | | MANNER OF DEATH | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | |
| SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | |
| SIGNATURE OF CLERGYMAN | | SIGNATURE OF BURIAL | |
| SIGNATURE OF FUNERAL HOME | | SIGNATURE OF CEMETERY | |
| SIGNATURE OF HEALTH DEPARTMENT | | SIGNATURE OF BALTIMORE | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3188

03175

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY HARFORD MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY HARFORD | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE | | c. LENGTH OF STAY IN 1b LIFE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 552 REVOLUTION ST. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Ella First Ida Middle Williams Last | | 4. DATE OF DEATH Month Mar. Day 11 Year 1961 | |
| 5. SEX FEMALE | 6. COLOR OR RACE BLACK | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH APR. 18, 1885 |
| 9. AGE (In years lost birthday) 75 yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME unk. | | 14. MOTHER'S MAIDEN NAME ELIZA BODELY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT GRAYSON P. WILLIAMS | | 18. ADDRESS 2006 M. BENTALOU ST, BALTO. 16, MD | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 442X Uremia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart disease
DUE TO (c) Cardio-Renal Insufficiency | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 10, 1960 to March 11, 1961 , that (I) (we) last saw the deceased alive on March 10, 1961 , and that death occurred at P. M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE George T. Stansbury | | 22b. DATE SIGNED 3/13/61 | |
| 22c. PHYSICIAN'S NAME (Type) George T. Stansbury | | 22d. ADDRESS 569 Revolution St. Havre de Grace, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF MAR 14 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY ST. JAMES CEM. | | 23d. LOCATION (City, town, or county) (State) HAVRE DE GRACE MD | |
| 24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell | | 25a. REC'D BY REGISTRAR MAR 15 '61 | |
| ADDRESS HAVRE DE GRACE MD | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

X

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BP

10115

CERTIFICATE OF DEATH

10115

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10

